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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 18&amp;21 Film G193 3-13-56 ams

01811

1825

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harford</u>		<u>2 Mns. - 5 days</u>		TOWN <u>Perryman</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Maple Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Ralph</u> (Middle) <u>William</u> (Last) <u>Ashford</u>				<u>Feb. 23</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Sept 1 - 1934</u>	<u>21</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ray Laborer</u>		<u>Heating Business</u>		<u>Va.</u>		<u>US</u>	
13. FATHER'S NAME <u>William Franklin Ashford</u>				14. MOTHER'S MAIDEN NAME <u>Cellic Elizabeth Shrader</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>218-32-6941</u>		<u>Wm. F. Ashford. Perryman Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
825X IMMEDIATE CAUSE (A) <u>Brain stem damage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Skull fracture</u>				2 mos.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Accident, Auto</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Highway</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Cresswell, Rt#543 Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12/18/55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Automobile accident</u>			
22. I hereby certify that I attended the deceased from <u>Dec. 18, 1955</u> , to <u>Feb. 23, 1956</u> , that I last saw the deceased alive on <u>Feb. 23, 1956</u> , end that death occurred at <u>12:05 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. K. Shrader</u>				ADDRESS (Street, city, town, state) <u>Harford Md</u> DATE SIGNED <u>2-23-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 26-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
24. REC'D BY REGISTRAR <u>A. L. Lewis m. cl.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Tarring</u>		ADDRESS <u>Aberdeen Md.</u>	
DATE <u>Feb. 28-1956</u>							

# CERTIFICATE OF DEATH

YOUR REFERENCE NUMBER OR DECLARATION

NAME

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BUREAU V. S.

FEB 29 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

# 3478 CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

01812

Reg. Dist. No. 185 -

1. PLACE OF DEATH COUNTY <u>Baltimore</u> <u>Maryland</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hamlet</u> TOWN <u>Hamlet</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED COUNTY <u>Baltimore</u> <u>Maryland</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hamlet</u> TOWN <u>Hamlet</u> STREET ADDRESS <u>Penicus W. Hall</u>	
3. NAME OF DECEASED (Type or Print) <u>Willie</u> (First) <u>Barfield</u> (Middle) <u>Barfield</u> (Last)		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>27</u> (Year) <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5/3/1902</u>
9. AGE last birthday <u>53</u> yrs.		10. AGE last birthday If under 1 year: Months <u>2</u> Days <u>27</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>lumber</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Willis Barfield</u>		14. MOTHER'S MAIDEN NAME <u>Josephine E. Barfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Bertine Johnson</u> <u>1519 Wilmore St.</u> <u>Baltimore, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Erosion cerebrum

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Amputation L thigh

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>1519 Wilmore St.</u>		(CITY OR TOWN) <u>Hamlet</u>	(COUNTY) <u>Baltimore</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2/27/56</u> <u>4</u> m.	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>Auto accident</u>			

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/1/56</u>	NAME OF SEMETERY OR CREMATORY <u>Williamston</u>	LOCATION (City, town, or county) <u>Williamston, N.C.</u>	(State) <u>N.C.</u>
DATE RECEIVED BY LOCAL REG. <u>Feb 27 1956</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		24. GENERAL DIRECTOR <u>Flanagan &amp; Tully</u> ADDRESS <u>Williamston, N.C.</u>	

BUREAU V. S.

FEB 29 1936

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01813

## 1843 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Aberdeen</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Aberdeen Rural #1</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Parsius Run, Rural #1</i>				STREET ADDRESS (If rural give location) <i>near Parsius Run</i>		1	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Varney</i> (Middle) <i>Arthur</i> (Last) <i>Beall</i>				(Month) <i>Feb.</i> (Day) <i>7th</i> (Year) <i>1946</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan 9th 1882</i>	9. AGE last birthday <i>74</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer self emp.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Leunel H. Beall</i>				14. MOTHER'S MAIDEN NAME <i>Charlotte Wilg's</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Wrs Varney H. Beall - Aberdeen #1</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Chronic Myocarditis - Hypertension</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4-12-1946</i> to <i>Feb 7</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Feb 6 1956</i> , and that death occurred at <i>10 PM</i> M, from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>		M.D. <i>John De Grace</i>		ADDRESS (Street, city, town, state) <i>Bel Air Pk Maryland</i>		DATE SIGNED <i>2/10/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/11/56</i>		NAME OF CEMETERY OR CREMATORY <i>Wt. Zion Cemetery</i>		LOCATION (City, town, of county) (State) <i>Bel Air Pk Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS <i>Aberdeen Md.</i>	
DATE <i>Feb. 11-56</i>							

1913 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Reg. No. 14

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Duration of illness

10. Name of physician

11. Name of funeral director

12. Name of undertaker

13. Name of cemetery

14. Name of burial place

15. Name of interment place

16. Name of place of burial

17. Name of place of interment

18. Name of place of burial

19. Name of place of interment

20. Name of place of burial

21. Name of place of interment

22. Name of place of burial

23. Name of place of interment

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BUREAU V. 2

FEB 14 1956

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1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Place of birth  
6. Date of death  
7. Place of death  
8. Cause of death  
9. Duration of illness  
10. Name of physician  
11. Name of funeral director  
12. Name of undertaker  
13. Name of cemetery  
14. Name of burial place  
15. Name of interment place  
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39. Name of place of interment  
40. Name of place of burial



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01814

## CERTIFICATE OF DEATH

1844

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>MARYLAND</u>		STATE <u>ROCKS</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural, Rocks</u>		<u>Hogers</u>		TOWN <u>ROCKS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Thomas W. Bosley</u>				<u>Feb. 24</u> 19 <u>56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>MARCH 31/1888</u>	<u>67</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Laborer</u>		<u>Farming</u>		<u>Maryland</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Thomas E Bosley</u>				<u>Elizabeth Bosley</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<u>Elizabeth Bosley Rocks</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>1 hr.?</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Chr. Cardio Vascular disease with hypertension</u>		<u>?</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>Cerebral thrombosis with hemiplegia</u>		<u>Mar. 1954</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>3-19</u> , 19 <u>54</u> , to <u>Feb. 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 22</u> , 19 <u>56</u> , and that death occurred at <u>56</u> M, from the causes and on the date stated above.							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Willard P. Hudson</u>				<u>M.D. Forest Hill, Md.</u>		<u>2-25-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>BURIAL</u>		<u>Feb 27-56</u>		<u>MT Zion</u>		<u>Beltir Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>2-28-56</u>		<u>Paula L. Howard</u>		<u>Martha E. Kuntz</u>			

# CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED

2. SEX

3. PLACE OF BIRTH

4. DATE OF BIRTH

5. PLACE OF DEATH

6. DATE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. MEDICAL EXAMINATION

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

BUREAU V. S.

MAR 2 1956

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FILED IN 15104

2. This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof shall be sent to the local health officer of the city or county in which the death occurred. It is the duty of the local health officer to see that this certificate is properly filled out and that it is filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof shall be sent to the local health officer of the city or county in which the death occurred. It is the duty of the local health officer to see that this certificate is properly filled out and that it is filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof shall be sent to the local health officer of the city or county in which the death occurred.



1826

## CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 HRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>71 HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>517 N. Adams</u>			
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>GORMAN</u> Last <u>BOYD</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/25/07</u>	9. AGE (In years last birthday) <u>59</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MICHAEL P. BOYD</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET CONNORS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W.I.</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>John Boyd, 517 N. Adams, Harford Shores</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular</u> <u>420.1</u> DUE TO <u>Hypertension Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Thrombosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1/10</u> , 19 <u>52</u> , to <u>2/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/22</u> , 19 <u>56</u> , and that death occurred at <u>10:40</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harford Shores Md.</u> DATE SIGNED <u>2/23/56</u>							
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.				PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/25/56</u>		<u>Mt. Carmel</u>		<u>Harford Shores Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence P. M. Harford Shores, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 2-25-56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 1845 FOR MEDICAL EXAMINERS

01816

Reg. Dist. No. 18

1. PLACE OF DEATH COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurens Place</u> TOWN <u>Laurens Place</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural #1 - (Robin Hood Road)</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurens Place</u> TOWN <u>Laurens Place</u> STREET ADDRESS (If rural, give location) <u>Robin Hood Road Area 1</u>	
3. NAME OF DECEASED (Type or Print) <u>Walter Charles Burkent</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>20</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>June 28 - 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer, self emp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>Thomas Burkentine</u>		14. MOTHER'S MAIDEN NAME <u>Mary Herman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-07-3168</u>	
		17. INFORMANT AND ADDRESS <u>Ted Burkentus #2 Baldwin Circle Aberdeen</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> Immediate cause <u>Arteriosclerotic CV disease</u> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ronald E Palmer M D Deputy Medical Examiner Harford County 2/20/56

23. BURIAL, CREMATION, REMOVAL - (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb 22 - 1956</u>	<u>Salem Methodist Cemetery</u>	<u>Tetta, York Co. Penna</u>	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb 22 - 56</u>	<u>Willie G. Perry</u>	<u>John E. Tarring</u>	<u>Aberdeen Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 27 1956  
BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No.

018123 -

1827

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvde Grace</u>		c. LENGTH OF STAY IN 1b <u>56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvde Grace</u>	
		d. STREET ADDRESS <u>146 Bloomsbury Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Victor George Coakley</u>		4. DATE OF DEATH <u>FEB. 27 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumber U.S. Chemical</u>	9. AGE (In years last birthday) <u>56</u> yrs.
		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
13. FATHER'S NAME <u>Eugene Coakley</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle Gilbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>199-07-965</u>	
		17. INFORMANT <u>Mrs. Willie S. Coakley Harvde Grace Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis Cardiac Osses</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aliscian</u> DUE TO (c) <u>Acute Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb-26, 1956</u> to <u>Feb-27 1956</u> , that I last saw the deceased alive on <u>Feb 27, 1956</u> , and that death occurred at <u>430 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harvde Grace Md</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Charles J. Hing</u> M.D.		PHYSICIAN'S NAME (Type) <u>Harvde Grace Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAR. 1, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>HARVDE GRACE, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harvde Grace Md.</u>		24a. REC'D BY REGISTRAR <u>DATE Feb-29-56</u>	24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF SHERIFF'S CLERK</p>	

BUREAU V. S.

MAR 5 - 1956

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**1846** FOR MEDICAL EXAMINERS

01818

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Oakington</u>		STREET ADDRESS (If rural, give location) <u>Connetquot St.</u>	
3. NAME OF DECEASED (Type or Print) <u>George Amos Curry</u>		4. DATE OF DEATH <u>February 16</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 5, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE last birthday <u>72</u> yrs. <u>11</u> under 1 year <u>11</u> under 24 hrs. <u>11</u> under 24 hrs.
13. FATHER'S NAME <u>Thomas Curry</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Motterey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT AND ADDRESS <u>Mrs. Sarah Jane Curry Harford Grace</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<u>422.1</u> Immediate cause (a) <u>Arteriosclerotic CV disease</u>		
Antecedent cause(s) (b) <u>Arteriosclerotic CV disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <u>Gerald E Palmer</u> M.D., Deputy Medical Examiner Baltimore Md.		DATE SIGNED <u>2/16/56</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-18-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Harmony Ch. Yard</u>
DATE REC'D BY LOCAL REG. <u>Feb 17-1956</u>	REGISTRAR'S SIGNATURE <u>U. L. Lewis</u>	24. FUNERAL DIRECTOR <u>H. Madison Mitchell</u>
		ADDRESS <u>Harford Grace, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1828

CERTIFICATE OF DEATH

018185-

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville 07K-21</u>	
c. LENGTH OF STAY IN 1b <u>8 days</u>		d. STREET ADDRESS <u>Arch St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>71 Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>W.</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward K. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Lizzie Davis (wife) Perryville, Md.</u>	
17. INFORMANT <u>Lizzie Davis (wife) Perryville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Chronic Myocarditis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Sclerosis - Arterio Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>August 7, 1951</u> to <u>Feb. 24, 1956</u> that I last saw the deceased alive on <u>Feb. 24, 1956</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. J. Benson</u> M.D.		ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u> DATE SIGNED <u>2/25/56</u>	
PHYSICIAN'S NAME (Type) <u>C. I. BENSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-27-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>North east</u>	22d. LOCATION (City, town, or county) (State) <u>North east, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson &amp; Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 2-25-1956</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

BUREAU V. S.

FEB 28 1971

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01820

## 1847 CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Abingdon</b>				c. LENGTH OF STAY IN 1b <b>50 yrs.,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rebecca</b> Middle <b>Dorsey</b> Last <b>Dorsey</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>19</b> Year <b>1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1875</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Servant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Edith Harris</b>		Address <b>Abingdon, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Hypertensive Cardiovascular disease</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/23</b> , 19 <b>55</b> , to <b>2/19</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2/16</b> , 19 <b>56</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>George T. Stansbury</b> M.D. <b>569 Revolution St., Havre de Grace 2/1956</b> <b>Md.</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		22d. LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. Mc Comas &amp; Son, Abingdon, Md.</b>				24a. REC'D BY REGISTRAR <b>Feb 22, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Norma Moore</b>	

BUREAU V. S.

FEB 27 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01821

## 1848 CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Jarrettsville</u>		<u>70 yrs</u>		TOWN <u>Jarrettsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last) <u>Alice Gertrude Eggleston</u>				<u>Feb 6<sup>th</sup></u> 19 <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Dec 13 1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Teacher (Retired)</u>					<u>Hess, Hartford Md</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph E. Eggleston</u>				<u>Emma Frances Blaney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>						<u>Miss Estelle Eggleston Jarrettsville Md</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
152X IMMEDIATE CAUSE (A) <u>Malnutrition</u>						<u>6 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Lack of Appetite &amp; Anemia</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinoma of Small Bowel</u>						<u>1 year</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>NONE</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>NONE</u>		<u>NONE</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>49</u> , to <u>JAN. 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JAN. 30</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> M. from the causes and on the date stated above.							
SIGNATURE <u>W. James Thomas</u>				DATE SIGNED <u>Feb. 6, 1956</u>			
				ADDRESS (Street, city, town, state) <u>Jarrettsville, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 9-56</u>		<u>Jarrettsville</u>		<u>Jarrettsville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>2-10-56</u>		<u>Willie Lownd</u>		<u>Martha E. Kirby Jarrettsville</u>		<u>2008</u>	

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BUREAU

FEB 14 1956

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INSTRUCTIONS

**1** be executed within **24 hours** after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01822

# 1849 CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY OR TOWN <u>Jarrettsville (Rural)</u>		LENGTH OF STAY (in this place) <u>86 yrs.</u>		CITY OR TOWN <u>(RURAL) JARRETTSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>George Edward Emrick</u>				<b>4. DATE OF DEATH</b> (Month) <u>Feb</u> (Day) <u>3rd</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>Feb 2 1870</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>1</u>	
11. BIRTHPLACE (State or foreign country) <u>Jarrettsville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Emrick</u>		14. MOTHER'S MAIDEN NAME <u>Catharine Hess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Charles H. Solomon, Rock Rd</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
4200 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>25 YRS</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized ARTERIOSCLEROSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Bronchiectasis</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>20 June 1955</u>, to <u>3 FEB</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1 Feb</u>, 19<u>56</u>, and that death occurred at <u>530</u> AM, from the causes and on the date stated above.</b>							
SIGNATURE <u>Thomas A. Mosley Jr.</u> M.D.				DATE SIGNED <u>3 Feb 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Feb 5-56</u>			
NAME OF CEMETERY OR CREMATORY <u>Salem</u>				LOCATION (City, town, or county) <u>Jarrettsville Harford Md</u>			
24. REC'D BY REGISTRAR <u>Priscilla Howard</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas A. Mosley Jr.</u> ADDRESS <u>Jarrettsville Md</u>			
DATE <u>2-7-56</u>							

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FEB 9 1930

BUREAU V. S.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH-BALTIMORE 12

01832

1. FULL NAME OF DECEASED

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

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BUREAU V. S.

FEB 8 1956

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01824

## 1829 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		TOWN <u>Aberdeen</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>#401 Wynwar Ave.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Milton</u> (Middle) <u>Eugene</u> (Last) <u>Fassnacht</u>				(Month) <u>Feb</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 31, 1878</u>	9. AGE last birthday <u>77</u> Yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gasoline Industries</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Fassnacht</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Lasher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>223-01-7287</u>		17. INFORMANT & ADDRESS <u>Mrs Milton E. Fassnacht, Aberdeen Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Coronary Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Coronary Arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10, 1956</u> , to <u>2/17, 1956</u> , that I last saw the deceased alive on <u>2/17, 1956</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>[Address]</u>		DATE SIGNED <u>2/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Feb 18-1956</u>		NAME OF CEMETERY OR CREMATORY <u>East Akron Cemetery</u>		LOCATION (City, town, or county) <u>Akron, Ohio</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>Feb. 18-56</u>							

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1830  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

01825

No. 181

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Aberdeen</u>		TOWN <u>Aberdeen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#6 Post Road.</u>		STREET ADDRESS (If rural, give location) <u>#6 Post Road.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Oliver</u>	(Middle) <u>D</u>	(Last) <u>Frock</u>	(Month) <u>February</u> (Day) <u>9</u> (Year) <u>1956</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>June 17 - 1895</u>
9. AGE last birthday: <u>60</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>West Virginia</u>	
11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Thomas Frock</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Barker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>yes</u> (If Yes, give war or dates of service) <u>war I</u>		16. SOCIAL SECURITY NO.: <u>220-22-0348</u>	
17. INFORMANT & ADDRESS: <u>Berkeley Springs W. Va.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Arteriosclerotic CVD disease</u>			
DUE TO			
Antecedent cause(s) (b)			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Lorred C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/9/56</u>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>2/10/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenway Cemetery</u>		LOCATION (City, town, or county) (State) <u>Berkeley Springs W. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Feb. 10 - 56</u>		24. FUNERAL DIRECTOR <u>John F. Barring Aberdeen Md.</u>	

BUREAU V. S.

FEB 14 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1851

## CERTIFICATE OF DEATH

01826

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>PERRYMAN</u>		<u>10 YRS</u>		TOWN <u>PERRYMAN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>MARY</u> (Middle) <u>ELLEN</u> (Last) <u>GILBERT</u>				<u>FEB.</u> <u>18</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>DEC. 10, 1888</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSE WIFE</u>		<u>HOME</u>		<u>MD</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>RICHARD HANNON</u>				<u>CATHERINE V. HOLLOWAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>DAKLEY B. GILBERT, PERRYMAN MD.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
260X IMMEDIATE CAUSE (A) <u>Chronic Hypertorial Degeneration</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes Mellitus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 17, 1956</u> , to <u>Feb. 18, 1956</u> , that I last saw the deceased alive on <u>Feb. 17, 1956</u> , and that death occurred at <u>12:45 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edward D. Holloway, M.D.</u>				ADDRESS (Street, city, town, state) <u>Perryman, Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2-21-1956</u>		<u>BAKER'S CEM.</u>		<u>HARFORD MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb. 20-56</u>		<u>Nellie Q. Perry</u>		<u>R. Madison Mitchell</u>		<u>HAVRE DE GRACE MD.</u>	

14-00000

BUREAU V. S.

FEB 23 1956

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01827

## 1831 CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Harvey de Grace</u>		<u>3 DAYS</u>		TOWN <u>Harvey de Grace</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>3185 Union Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>IRA Herman Hall</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 16 1956</u>			
FIRST (First) <u>IRA</u>		MIDDLE (Middle) <u>HERMAN</u>		LAST (Last) <u>HALL</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>5/7/1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVILIAN GUNNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.P.G.</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert G Hall</u>				14. MOTHER'S MAIDEN NAME <u>Laura B. No. ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>214-18-6440</u>		17. INFORMANT & ADDRESS <u>3185 UNION AVE. THE VICTORIA HALL HARVEY DE GRACE</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4438 IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>				3 days			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Hemorrhage</u>				11 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive Cardiovascular Disease</u>				yes			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> , to <u>Feb 16, 1956</u> , that I last saw the deceased alive on <u>Feb 16</u> , 19 <u>56</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frederick J. Stetson</u> M.D. <u>1711 Hill Blvd. Aberdeen Md.</u>				DATE SIGNED <u>2/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-19-1956</u>		NAME OF CEMETERY OR CREMATORY <u>DARLINGTON CEM.</u>		LOCATION (City, town, or county) (State) <u>HARFORD CO. MD.</u>	
24. REC'D BY REGISTRAR <u>Feb 17 - 1956</u>		REGISTRAR'S SIGNATURE <u>C. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Madison Mitchell</u>		ADDRESS <u>HARVEY DE GRACE</u>	

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased (Print or write full name)

2. Sex (Male or Female) and Age (Years, Months, Days)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Immediate cause)

9. Cause of death (Underlying cause)

10. Cause of death (Contributing cause)

11. Name of attending physician

12. Name of medical examiner

13. Name of funeral director

14. Name of informant

15. Signature of informant

16. Signature of medical examiner

17. Signature of funeral director

18. Name of registrar

19. Signature of registrar

20. Date of registration

21. Place of registration

22. Name of registrar

23. Signature of registrar

24. Date of registration

25. Place of registration

26. Name of registrar

27. Signature of registrar

28. Date of registration

29. Place of registration

30. Name of registrar

31. Signature of registrar

32. Date of registration

33. Place of registration

34. Name of registrar

35. Signature of registrar

36. Date of registration

37. Place of registration

38. Name of registrar

39. Signature of registrar

40. Date of registration

41. Place of registration

42. Name of registrar

43. Signature of registrar

44. Date of registration

45. Place of registration

46. Name of registrar

47. Signature of registrar

48. Date of registration

49. Place of registration

50. Name of registrar

51. Signature of registrar

52. Date of registration

53. Place of registration

54. Name of registrar

55. Signature of registrar

56. Date of registration

57. Place of registration

BUREAU V. S.

FEB 20 1956

RECEIVED

1. Name of deceased (Print or write full name)  
2. Sex (Male or Female) and Age (Years, Months, Days)  
3. Date of birth (Month, Day, Year)  
4. Place of birth (City, State, Country)  
5. Usual residence (City, State, Country)  
6. Date of death (Month, Day, Year)  
7. Time of death (Hour, Minute)  
8. Cause of death (Immediate cause)  
9. Cause of death (Underlying cause)  
10. Cause of death (Contributing cause)  
11. Name of attending physician  
12. Name of medical examiner  
13. Name of funeral director  
14. Name of informant  
15. Signature of informant  
16. Signature of medical examiner  
17. Signature of funeral director  
18. Name of registrar  
19. Signature of registrar  
20. Date of registration  
21. Place of registration  
22. Name of registrar  
23. Signature of registrar  
24. Date of registration  
25. Place of registration  
26. Name of registrar  
27. Signature of registrar  
28. Date of registration  
29. Place of registration  
30. Name of registrar  
31. Signature of registrar  
32. Date of registration  
33. Place of registration  
34. Name of registrar  
35. Signature of registrar  
36. Date of registration  
37. Place of registration  
38. Name of registrar  
39. Signature of registrar  
40. Date of registration  
41. Place of registration  
42. Name of registrar  
43. Signature of registrar  
44. Date of registration  
45. Place of registration  
46. Name of registrar  
47. Signature of registrar  
48. Date of registration  
49. Place of registration  
50. Name of registrar  
51. Signature of registrar  
52. Date of registration  
53. Place of registration  
54. Name of registrar  
55. Signature of registrar  
56. Date of registration  
57. Place of registration

1832

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 181

1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Alabama</u> COUNTY <u>Jefferson</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Birmingham</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Flying Clipper Trailer Court</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Pierce</u>	(Middle) <u>Morgan</u>	(Last) <u>Henry</u>
4. DATE OF DEATH	(Month) <u>February</u>	(Day) <u>11</u>	(Year) <u>1956</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct 25-1911</u>
9. AGE (last birthday) <u>44</u> yrs.		If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet metal</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert H. Henry</u>		14. MOTHER'S MAIDEN NAME <u>Lilly Brooks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>  </u>	
(If yes, give war or dates of service) <u>war II</u>		17. INFORMANT AND ADDRESS <u>Robert's Valley Chapel Funeral Home, Birmingham Ala.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) A sphixia due to fire

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>Aberdeen</u>	(COUNTY) <u>Harford</u>	(STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2/11/56</u> <u>8 A.M.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>A trailer caught fire</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>Feb 12-1956</u>	NAME OF CEMETERY OR CREMATORY <u>  </u>	LOCATION (City, town, or county) (State) <u>Birmingham Alabama</u>
DATE REC'D BY LOCAL REG. <u>Feb 11-1956</u>	REGISTRAR'S SIGNATURE <u>Nellie G. Perry</u>	24. FUNERAL DIRECTOR <u>John G. Farving</u>	ADDRESS <u>Aberdeen MD</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 14 1956

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01831

1852

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford Co.</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>RURAL</u> <u>ABERDEEN</u>		CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Route 40 R.D. #1 Aberdeen</u> Md.	
3. NAME OF DECEASED (Type or Print)	(First) <u>FELIX</u>	(Middle) <u>A.</u>	(Last) <u>McNALLY</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Felix A. McNally</u>		14. MOTHER'S MAIDEN NAME <u>Alice McGovern</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. C.M. Walker-Route 40 R.D.1</u>		<u>Aberdeen, Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X Immediate cause (a) <u>Intracerebral hemorrhage</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertensive, arteriosclerotic cardiovascular disease</u>	<u>10 years</u>
(c)	

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 6, 1956, to Feb 10, 1956, that I last saw the deceased alive on Feb 8, 1956, and that death occurred at 11:20 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/13/56</u>	NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>	LOCATION (City, town, or county) <u>Balto. City</u>	(State)
DATE REC'D BY LOCAL REG. <u>2-13-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>WIEDEFELD &amp; SON</u>	ADDRESS <u>GREENMOUNT AVE &amp; 22ND</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7 Photo



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1853 CERTIFICATE OF DEATH

01832

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>MARYLAND</u>		STATE <u>Tennessee</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aberdeen</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Athens</u>		79 x - 3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US Army Hospital</u> <u>Aberdeen Proving Ground</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>JAMES</u> (First) <u>RAY</u> (Middle) <u>MURPHY</u> (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 18</u> 19 <u>56</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>23 Apr 23</u>	<b>9. AGE last birthday</b> <u>32</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>US Army</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Tennessee</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Deceased (Unknown)</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Deceased (Unknown)</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Yes</u> <u>1944</u>		<b>16. SOCIAL SECURITY NO.</b> <u>410-20-7653</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Official US Army</u> <u>Records, (phone) ACC, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>825X IMMEDIATE CAUSE (A)</b> <u>Subarachnoid hemorrhage, extensive</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> -	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Fracture 3-4-5-6 ribs and 2nd costal cartilage on right.</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Fracture, mandible, bilateral</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Laceration, right lung with hemothorax</u>							
<b>19a. DATE OF OPERATION</b> <u>None (DOA)</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <u>Highway</u>		<b>21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)</b> <u>Highway</u>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b> <u>Route #40, between Aberdeen and Bigwood, Md</u>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <u>12 2000 Feb 18 56</u>		<b>21e. INJURY OCCURRED</b> <u>White</u> <input type="checkbox"/> <u>Not white</u> <input checked="" type="checkbox"/> <u>at work</u> <input type="checkbox"/> <u>at work</u> <input checked="" type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>Vehicle accident</u>			
<b>22. I hereby certify that I attended the deceased from <u>DOA</u>, 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>J. Stearns, Capt, Reg</u> M.D. <u>US Army Hospital Aberdeen Proving Ground</u>				<b>DATE SIGNED</b> <u>Feb 20 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Removal</u>		<b>DATE THEREOF</b> <u>Feb 20th 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Athens Tennessee</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Athens Tennessee</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Feb 20 - 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mellie G. Perry</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John G. Farring</u> ADDRESS <u>Aberdeen Md.</u>			

1999

254

10

BUREAU V. S.

FEB 23 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01833

## 1854 CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Rural</u> <u>Bel Air</u>		<u>3 years</u>		TOWN <u>Rural</u> <u>Bel Air</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10				/			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Martha</u> (Middle) <u>NELSON</u> (Last)				<u>February 10</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Col.</u>	<u>Widow</u>	<u>UNKNOWN</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Harford Co., Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>UNKNOWN</u>				<u>Annie Gones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Clarence Johnson</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
422.1 IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO						<u>death</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Chr. cardio-vascular disease</u>						<u>?</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January 20</u> <u>1956</u> , to <u>February 10</u> <u>1956</u> , that I last saw the deceased alive on <u>Feb. 7</u> , <u>1956</u> , and that death occurred at <u>6:45a</u> <u>M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Midland P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>February 10, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Feb 13/56</u>		<u>Tabernacle</u>		<u>BENSON Harford Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2-10-56</u>		<u>Priscilla Foxwood</u>		<u>Joseph J. Foster</u>		<u>Bel Air Md</u>	

11223

MAINE STATE DEPARTMENT OF HEALTH-BALTIMORE

# CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, first, middle)

2. DECEASED'S SEX (Male or Female)

3. DECEASED'S AGE (Years, months, days)

4. DECEASED'S BIRTH DATE (Month, day, year)

5. DECEASED'S BIRTH PLACE (City, town, village, county, state)

6. DECEASED'S OCCUPATION

7. DECEASED'S MARITAL STATUS (Single, Married, Widowed, Divorced)

8. DECEASED'S RACE

9. DECEASED'S RELIGION

10. DECEASED'S USUAL RESIDENCE (City, town, village, county, state)

11. DECEASED'S DATE OF DEATH (Month, day, year)

12. DECEASED'S TIME OF DEATH (Hour, minute)

13. DECEASED'S PLACE OF DEATH (City, town, village, county, state)

14. DECEASED'S CAUSE OF DEATH (Disease, injury, accident, etc.)

15. DECEASED'S MANNER OF DEATH (Natural, suicide, homicide, accident, etc.)

16. DECEASED'S SIGNATURE (Name of decedent)

17. DECEASED'S SIGNATURE (Name of decedent)

18. DECEASED'S SIGNATURE (Name of decedent)

19. DECEASED'S SIGNATURE (Name of decedent)

20. DECEASED'S SIGNATURE (Name of decedent)

21. DECEASED'S SIGNATURE (Name of decedent)

22. DECEASED'S SIGNATURE (Name of decedent)

23. DECEASED'S SIGNATURE (Name of decedent)

24. DECEASED'S SIGNATURE (Name of decedent)

25. DECEASED'S SIGNATURE (Name of decedent)

26. DECEASED'S SIGNATURE (Name of decedent)

27. DECEASED'S SIGNATURE (Name of decedent)

28. DECEASED'S SIGNATURE (Name of decedent)

29. DECEASED'S SIGNATURE (Name of decedent)

30. DECEASED'S SIGNATURE (Name of decedent)

BUREAU V. S.

FEB 14 1956

RECEIVED

1833 **CERTIFICATE OF DEATH**

Reg. Dist. No. 187

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Harford</b>		STATE <b>Maryland</b>		COUNTY <b>Harford</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Grafton Shop Road</b>				STREET ADDRESS (If rural give location) <b>Grafton Shop Road</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Mrs. Catherine Price</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>February 2nd 1956</b>			
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>	<b>8. DATE OF BIRTH</b> <b>20 Jan 1883</b>		<b>9. AGE last birthday</b> <b>73 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>at home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Charles Dieter</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Smith</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. M. Eliz. Treadwell, Box 266 Bel Air Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>422!</b> IMMEDIATE CAUSE (A) <b>Cardio-respiratory failure</b>						<b>33 hours</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Cerebral embolus</b>						<b>33 hours</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Congestive heart failure</b>						<b>1 year</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Arteriosclerotic cardiovascular Dis.</b>						<b>4 years</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from....., 19 49, to 2 Feb, 19 56, that I last saw the deceased alive on 1 Feb 56, and that death occurred at 1215 PM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>M. Eliz. Treadwell</i>				<b>ADDRESS</b> (Street, city, town, state) <b>M.D. 138 N. Main Bel Air, Md.</b>		<b>DATE SIGNED</b> <b>3 Feb 56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Feb. 6, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Priscilla Forward</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>			

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



# CERTIFICATE OF DEATH

1933

Part One of

1. LOCAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. MANNER OF DEATH

4. CAUSE OF DEATH

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. CAUSE OF DEATH

12. DATE OF DEATH

13. TIME OF DEATH

14. PLACE OF DEATH

15. CAUSE OF DEATH

16. DATE OF DEATH

17. TIME OF DEATH

18. PLACE OF DEATH

19. CAUSE OF DEATH

20. DATE OF DEATH

21. TIME OF DEATH

22. PLACE OF DEATH

23. CAUSE OF DEATH

24. DATE OF DEATH

25. TIME OF DEATH

26. PLACE OF DEATH

27. CAUSE OF DEATH

28. DATE OF DEATH

29. TIME OF DEATH

30. PLACE OF DEATH

31. CAUSE OF DEATH

32. DATE OF DEATH

33. TIME OF DEATH

34. PLACE OF DEATH

35. CAUSE OF DEATH

36. DATE OF DEATH

37. TIME OF DEATH

38. PLACE OF DEATH

39. CAUSE OF DEATH

40. DATE OF DEATH

41. TIME OF DEATH

42. PLACE OF DEATH

43. CAUSE OF DEATH

44. DATE OF DEATH

45. TIME OF DEATH

46. PLACE OF DEATH

47. CAUSE OF DEATH

48. DATE OF DEATH

49. TIME OF DEATH

50. PLACE OF DEATH

51. CAUSE OF DEATH

52. DATE OF DEATH

53. TIME OF DEATH

54. PLACE OF DEATH

55. CAUSE OF DEATH

56. DATE OF DEATH

57. TIME OF DEATH

58. PLACE OF DEATH

59. CAUSE OF DEATH

60. DATE OF DEATH

61. TIME OF DEATH

62. PLACE OF DEATH

63. CAUSE OF DEATH

64. DATE OF DEATH

65. TIME OF DEATH

66. PLACE OF DEATH

67. CAUSE OF DEATH

68. DATE OF DEATH

69. TIME OF DEATH

70. PLACE OF DEATH

71. CAUSE OF DEATH

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78. PLACE OF DEATH

79. CAUSE OF DEATH

80. DATE OF DEATH

81. TIME OF DEATH

82. PLACE OF DEATH

83. CAUSE OF DEATH

84. DATE OF DEATH

85. TIME OF DEATH

86. PLACE OF DEATH

87. CAUSE OF DEATH

88. DATE OF DEATH

89. TIME OF DEATH

90. PLACE OF DEATH

91. CAUSE OF DEATH

92. DATE OF DEATH

93. TIME OF DEATH

94. PLACE OF DEATH

95. CAUSE OF DEATH

96. DATE OF DEATH

97. TIME OF DEATH

98. PLACE OF DEATH

99. CAUSE OF DEATH

100. DATE OF DEATH

101. TIME OF DEATH

102. PLACE OF DEATH

103. CAUSE OF DEATH

104. DATE OF DEATH

105. TIME OF DEATH

106. PLACE OF DEATH

107. CAUSE OF DEATH

108. DATE OF DEATH

109. TIME OF DEATH

110. PLACE OF DEATH

111. CAUSE OF DEATH

112. DATE OF DEATH

113. TIME OF DEATH

114. PLACE OF DEATH

115. CAUSE OF DEATH

BUREAU V. S.

FEB 8 1933

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1834

## CERTIFICATE OF DEATH

01835

Reg. Dist. No. 183-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre &amp; Grace.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo, MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>71 Harford Memorial Hosp.</u>				d. STREET ADDRESS <u>07X-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Arthur</u> Last <u>RAGAN</u>				4. DATE OF DEATH Month <u>February</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-12 1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Conowingo, Cal &amp; Md SA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Ragan</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, no. or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-34-3331</u>		17. INFORMANT <u>Mrs John Ragan Conowingo Md.</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis and hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive and arteriosclerotic Cardiovas-</u> DUE TO <u>Cular disease</u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>not known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Congestion of lungs.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 11th, 1956</u> , to <u>Feb. 29th, 1956</u> , that I last saw the deceased alive on <u>Feb. 29th, 1956</u> , and that death occurred at <u>125 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Leo, M.D.</u>				ADDRESS (Street, city or town, state) <u>211 N. Union Ave., Harre de Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Leo, M.D.</u>				DATE SIGNED <u>Feb. 29th, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar 4, 1956</u>		<u>Pleasant Grove, Pa.</u>		<u>Peach Bottom Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson, Rising Sun Md.</u>				24a. REC'D BY REGISTRAR <u>Mar. 4-56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

CERTIFICATE OF DEATH

1234

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 15 1956</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 15 1956</i>		DATE OF SIGNATURE <i>Jan 15 1956</i>	

BUREAU V. S.

MAR 6 1956

RECEIVED

## 1835 CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAVRE DE GRACE</u>		<u>LIFE</u>		TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>NORMAN</u> (Middle) <u>WIDMER</u> (Last) <u>REYNOLDS</u>				(Month) <u>Feb.</u> (Day) <u>11</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>SEPT. 17, 1890</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FIREMAN</u>		<u>CANNING HOUSE</u>		<u>MD</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>THOMAS I REYNOLDS</u>				<u>CATHERINE SCHUTT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>YES WORLD WAR #1</u>				<u>215-12-1568</u>		<u>ST. W. REYNOLDS, PERRYVILLE MD.</u>	
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>Leland C Palmer</u>				ADDRESS (Street, city, town, state) <u>Deputy Medical Examiner</u>		DATE SIGNED <u>2/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2-14-1956</u>		<u>ANGEL HILL CEM</u>		<u>HAVRE DE GRACE, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb. 14-1956</u>		<u>C. L. Lewis M.D.</u>		<u>R. Madison Mitchell</u>		<u>HAVRE DE GRACE, MD</u>	

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01837

1836

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bel Air</u>		<u>30 years</u>		TOWN <u>Bel Air</u>		<u>32</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Lucy Alurta Rhodes</u>				<b>4. DATE OF DEATH</b> (Month) <u>February</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 18, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-24-5373</u>		17. INFORMANT & ADDRESS <u>Edgar Rhodes</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertensive Cardio-vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Cerebral Thrombosis (May, 1955 &amp; Nov., 1955)</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>Feb. 25</u> , 19 <u>56</u> , to <u>Feb. 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 25</u> , 19 <u>56</u> , and that death occurred at <u>7:20 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				DATE SIGNED <u>February 27, 1956</u>			
ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Centre City Forest Hill, Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. W. Kirk</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. S. Bailey</u>		ADDRESS <u>Norlington Md</u>	
DATE <u>March 1, 1956</u>							



CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

DATE OF DEATH

PLACE OF DEATH

COUNTY

REGISTRATION DISTRICT

TIME OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

DATE OF MARRIAGE

NAME OF SPOUSE

RELATIONSHIP

DATE OF INTERMENT

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

DATE OF CREMATION

NAME OF CREMATOR

NAME OF CEMETERY

NAME OF INTERMENT

DATE OF EXHUMATION

NAME OF EXHUMATOR

NAME OF CEMETERY

NAME OF INTERMENT

DATE OF REINTERMENT

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BUREAU V. S.

MAR 6 1956

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1855 CERTIFICATE OF DEATH

01838

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>BELAIR RD</u>		<u>52 YEARS</u>		TOWN <u>BELAIR RD</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walters Nursing Home</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>CORA E ROLOSON</u>				<u>Feby 4 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<u>F</u>	<u>W</u>	<u>Single</u>	<u>Jan 10-1871</u>	<u>85</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>House duties</u>		<u>House duties</u>		<u>Catonsville Md</u>		<u>US</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Richard Roloson</u>				<u>Frances Cash</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>✓</u>		<u>✓</u>		<u>Alger S Roloson</u> <u>BELAIR MD RD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						<u>6 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>Probably 10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Nov. 16</u>, 19<u>55</u>, to <u>Feb. 4</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Feb. 4</u>, 19<u>56</u>, and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>ADDRESS</b> (Street, city, town, state)				<b>DATE SIGNED</b>	
<u>Robert Barthel</u>		<u>Forest Hill, Maryland</u>				<u>2-6-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b> (State)	
<u>BURIAL</u>		<u>Feb 7/56</u>		<u>Friends Burial Grounds</u>		<u>2506 HARTFORD ROAD BALTIMORE MD</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>2.6.56</u>		<u>Phyllis Greenwood</u>		<u>Joseph J. Foster Bel Air Md</u>			
<b>DATE</b>							



## CERTIFICATE OF DEATH

Reg. Dist. No. 1837

01839-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE de GRACE</u>				c. LENGTH OF STAY IN 1b <u>12 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hosp.</u>				d. STREET ADDRESS <u>617 Juniata St</u>			
3. NAME OF DECEASED (Type or print) <u>Dolores ScILLI</u>				4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/1897</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Giovanna Di Amantis</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Mrs. Robert Whitney</u>				Address <u>Ontario St., Harford County, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerosis Hypertension</u> (c) <u>Chronic</u> <u>Small Bladder Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 27, 1956</u> , to <u>Feb 28, 1956</u> , that I last saw the deceased alive on <u>Feb 28</u> , 19 <u>56</u> , and that death occurred at <u>745</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.				DATE SIGNED <u>Mar 2/29/56</u>			
PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Egan</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Han, Harford County, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Mar 3-56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		MOBILE		MOBILE		ALABAMA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
SALES MAN		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		5' 10"		175	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
APR 4 1968		MOBILE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		MEDICINE		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		PLACE		CAUSE		MANNER		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
APR 4 1968		MOBILE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		MEDICINE		NO	

BUREAU V. S.

MAR 6 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

01840

1856 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 180

1. PLACE OF DEATH - COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Pennsylvania</b> COUNTY <b>Delaware</b>					
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Abingdon</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <b>104 Mc Kinley Ave.,</b>					
3. NAME OF DECEASED (Type or Print) <b>Elwood T. Sterling</b>		4. DATE OF DEATH <b>February 24 1956</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>Mar. 3, 1908</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>contractor</b>	9. AGE last birthday <b>47</b> yrs. <table border="1"><tr><td>If under 1 year</td><td>If under 24 hrs.</td></tr><tr><td>Months</td><td>Days</td></tr></table>	If under 1 year	If under 24 hrs.	Months	Days
If under 1 year	If under 24 hrs.						
Months	Days						
11. BIRTHPLACE (State or foreign country) <b>Bloomsburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Sterling</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>194-07-8982</b>					
		17. INFORMANT AND ADDRESS <b>Jennie Sterling, Bloomsburg, Penna.,</b>					

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<b>973.1</b> Immediate cause (a) <b>Poisoning due to Carbon Monoxide</b> Antecedent cause(s) (b) <b>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b> (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, or office bldg., etc.) <b>Field</b> (CITY OR TOWN) <b>Abingdon</b> (COUNTY) <b>Harford</b> (STATE) <b>Md</b>	TIME (Month) (Day) (Year) (Hour) OF INJURY <b>2/24/56</b> m. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <b>Fired auto exploded into car</b>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE <b>Lerald C Palmer MD</b> (Degree or title)		DATE SIGNED <b>2/24/56</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>	DATE THEREOF <b>2/25/1956</b>	NAME OF CEMETERY OR CREMATORY <b>Baker Funeral Home</b>	LOCATION (City, town, or county) (State) <b>Bloomsburg, Columbia, Pa.</b>
DATE REC'D BY LOCAL REG <b>Feb 28, 1956</b>	REGISTRAR'S SIGNATURE <b>Norma S. Moore</b>	24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1956

BUREAU V. 3



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01841

## 1838 CERTIFICATE OF DEATH

Reg. Dist. No. 180-

1. PLACE OF DEATH HARFORD MARYLAND COUNTY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED MARYLAND HARFORD STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAVRE DE GRACE		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN PERRYMAN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD MEMORIAL HOSPITAL		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) MARY S. TAYLOR TANNER		4. DATE OF DEATH February 1 1956	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH 4-2-1878
9. AGE last birthday 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) N. J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH W. TAYLOR		14. MOTHER'S MAIDEN NAME ANNA E. STOCKHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT & ADDRESS Son Lynn T. Tanner Jr. Aberdeen Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) Vascular collapse (post-operative)			42 hrs.
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertensive cardio vascular disease (C) Tumor of rectum			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 1-30-56		19b. MAJOR FINDINGS OF OPERATION Tumor of rectum	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-2, 1955, to 2-1, 1956, that I last saw the deceased alive on 2-1, 1956, and that death occurred at 3:05 P.M. from the causes and on the date stated above.			
SIGNATURE James W. C. Finney		DATE SIGNED 330 S. Union Ave, Havre de Grace, Md. 2-1-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR G. L. Lewis M.D.	
DATE Feb. 4-1956		25. FUNERAL DIRECTOR'S SIGNATURE John F. Garrison Aberdeen Md.	

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**THE UNIVERSITY OF CHICAGO**

BUREAU A. S.

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FEB 7 1956

1839

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>9 DAYS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Aberdeen Md.</u>				d. STREET ADDRESS <u>ABERDEEN Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Virginia</u> Last <u>VERMILLION</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/25/1891</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND BALTO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Clinton COOKE</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Dunn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Ma Francis E. Vermillion R.F.D. 1, Aberdeen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-9</u> , 19 <u>56</u> , to <u>2-25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>56</u> , and that death occurred at <u>3:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James McC. Finney</u> M.D.				ADDRESS (Street, city or town, state) <u>330 S. Union Ave., Haver de Grace Md.</u> DATE SIGNED <u>2-27-56</u>			
PHYSICIAN'S NAME (Type) <u>JAMES MCC. FINNEY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Balto. National</u>		22d. LOCATION (City, town, or county) (State) <u>5501 Frederick Ave</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u> ADDRESS <u>90 Hollins St.</u>				24a. REC'D BY REGISTRAR <u>Dr. R. L. Lewis</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**BUREAU V. S.**

FEB 29 1956

RECEIVED

## 1857 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>HARFORD</b>	MARYLAND	STATE <b>MD.</b>	COUNTY <b>HARFORD</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>CARDIFF</b>	LENGTH OF STAY (in this place) <b>28 YRS.</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>CARDIFF</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>		STREET ADDRESS (If rural give location) <b>X</b>	

3. NAME OF DECEASED: (First) (Middle) (Last) <b>WILLIAM HENRY WELCH</b>			4. DATE (Month) (Day) (Year) OF DEATH: <b>FEB. 15, 1956</b>		
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>MARRIED</b>	8. DATE OF BIRTH: <b>JUNE 10, 1887</b>	9. AGE last birthday <b>68</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>AMMUNITION LOADER</b>	10B. KIND OF BUSINESS OR INDUSTRY: <b>U.S. G.O.U.</b>	11. BIRTHPLACE (State or foreign country): <b>DELTA, PA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME: <b>THOMAS WELCH</b>	14. MOTHER'S MAIDEN NAME: <b>REBECCA DICK</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <b>No</b> (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>215-03-0428</b>	17. INFORMANT & ADDRESS: <b>ELLEN G. WELCH, CARDIFF, MD.</b>
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18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <b>Nephritis</b>	DUE TO	
ANTECEDENT CAUSE (S) <b>Arteriosclerotic C-V Disease</b>	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Coronary Thrombosis</b>	
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19A. DATE OF OPERATION: <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from <b>Jan 1955</b> , to <b>Feb 15, 1956</b> , that I last saw the deceased alive on <b>Feb 15, 1956</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above.	
SIGNATURE <b>Jonah A. Hunt, M.D.</b>	DATE SIGNED <b>2/17/56</b>
ADDRESS <b>Delta, Pa.</b>	

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	DATE THEREOF <b>2-18-56</b>	NAME OF CEMETERY OR CREMATORY <b>ST. MARYS</b>	LOCATION (City, town, or county) (State) <b>PYLESVILLE, MD.</b>
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DATE REC'D BY LOCAL REGISTRAR <b>2-18-56</b>	REGISTRAR'S SIGNATURE <b>Prueella Lowwood</b>	24. FUNERAL DIRECTOR <b>JOHN H. HARKINS, DELTA, PA.</b>	ADDRESS
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BUREAU V. E.

FEB 21 1956

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01844

1840

## CERTIFICATE OF DEATH

Reg. Dist. No. 183-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAVRE DE GRACE</u>		<u>50 YRS</u>		TOWN <u>HAVRE DE GRACE</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>515 FOUNTAIN ST.</u>				STREET ADDRESS (If rural give location) <u>515 FOUNTAIN ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MABEL</u> (Middle) <u>SYDONIA</u> (Last) <u>WHITEHEAD</u>				(Month) <u>FEB.</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>JAN. 16, 1879</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSE WIFE</u>		<u>HOME</u>		<u>MD</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>GEORGE F. LYDAIRD</u>				<u>SUSANNA M. WATKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>MR. GUSTAVUS WHITEHEAD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
592X IMMEDIATE CAUSE (A)				<u>Hemiplegia - Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Chronic Diffuse Impairment</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> to <u>Feb 7, 1956</u> , that I last saw the deceased alive on <u>Feb 7, 1956</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Harv. &amp; Lila, MD</u>		DATE SIGNED <u>2/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>FEB. 10, 1956</u>		<u>IVY HILL CEM.</u>		<u>PRINCE GEORGE CO., MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>[Signature]</u>		<u>[Signature]</u>		<u>HARVRE DE GRACE MD</u>	
DATE <u>Feb. 9 - 1956</u>							

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

DATE OF DEATH

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. PLACE OF BIRTH

8. DATE OF BIRTH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF DEATH

12. DATE OF DEATH

13. TIME OF DEATH

14. PLACE OF DEATH

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF DEATH

18. DATE OF DEATH

19. TIME OF DEATH

20. PLACE OF DEATH

21. DATE OF DEATH

22. TIME OF DEATH

23. PLACE OF DEATH

24. DATE OF DEATH

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31. TIME OF DEATH

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37. TIME OF DEATH

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51. DATE OF DEATH

52. TIME OF DEATH

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54. DATE OF DEATH

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79. TIME OF DEATH

80. PLACE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1858

## CERTIFICATE OF DEATH

### 01845180

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>				c. LENGTH OF STAY IN 1b <b>36</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Joppa</b>			
3. NAME OF DECEASED (Type or print) <b>Amelia</b> First <b>Willick</b> Last				4. DATE OF DEATH Month <b>Feb.</b> Day <b>18</b> Year <b>1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Dec. 15, 1882</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Strums Schaefer</b>				14. MOTHER'S MAIDEN NAME <b>Cathie Fink</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>William H. Willick</b>		Address <b>Joppa, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Acute pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis of V. D.</b> DUE TO <b>10 yrs</b> (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b> <b>Diabetes Mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June, 1946</b> , to <b>Feb</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Feb 18, 1956</b> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Ralph Horky</b> M.D.				ADDRESS (Street, city or town, state) <b>Churchville Maryland.</b> DATE SIGNED <b>Feb</b>			
PHYSICIAN'S NAME (Type) <b>J. Ralph Horky</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 21, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens</b>		22d. LOCATION (City, town, or county) (State) <b>Bradshaw, Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McComas &amp; Son</b>				ADDRESS <b>Abingdon Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Feb 22, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Norma Moore</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES EARL RAY		M		39		JAN 5 1917		MOBILE, ALABAMA		Pilot	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		OTHER	
DATE OF MARRIAGE		DATE OF DIVORCE		DATE OF WIDOWED		DATE OF OTHER		DATE OF OTHER		DATE OF OTHER	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
APR 4 1968		10:00 PM		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		100-100000	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
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THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR THE PURPOSES OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01846

## CERTIFICATE OF DEATH

1841

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE DE GRACE</u>		LENGTH OF STAY (in this place) <u>6 HRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ABERDEEN</u>		<u>31</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP</u>				STREET ADDRESS (If rural give location) <u>203 S. ROGERS</u>		<u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>CHARLES OSCAR WOLTERSBERGER</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>FEBRUARY 1 19 54</u>			
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>June 22-1894</u>	<b>9. AGE last birthday</b> <u>61</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>BIO RAILROAD</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Turnout Supt.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>PENNSYLVANIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>CHARLES WOLTERSBERGER</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>GERTRUDE PARKS</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>unk.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Ethel J. Woltersberger Aberdeen Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>331X IMMEDIATE CAUSE (A)</b> <u>Cerebro-Vascular Accident</u>						<u>7 hours</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Acute Hypertensive Crisis</u>						<u>12 hours</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Gen. Arteriosclerosis with BP 260/160</u>						<u>5 years</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 31, 1956</u> <b>to</b> <u>Jan 31, 1956</u> <b>that I last saw the deceased</b> <u>alive on</u> <u>Jan 31, 1956</u> <b>and that death occurred at</b> <u>12:40</u> <b>M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>A. Sandeeshi M.D.</u>		<b>M.D.</b> <u>Bel Air, Md.</u>		<b>ADDRESS (Street, city, town, state)</b> <u>Feb 1st 1956</u>		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Removal</u>		<b>DATE THEREOF</b> <u>2/2/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Old Yellow Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Northwood Penna.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>G. L. Lewis M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John E. Tarring Aberdeen Md.</u>		<b>ADDRESS</b>	
<b>DATE</b> <u>Feb 4 1956</u>							



# CERTIFICATE OF DEATH

1861

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF COUNTY

21. SIGNATURE OF CITY

22. SIGNATURE OF TOWNSHIP

23. SIGNATURE OF PARISH

24. SIGNATURE OF VILLAGE

25. SIGNATURE OF HAMLET

26. SIGNATURE OF CENSUS TRACT

27. SIGNATURE OF BLOCK

28. SIGNATURE OF HOUSE

29. SIGNATURE OF ROOM

30. SIGNATURE OF BED

31. SIGNATURE OF CHAIR

32. SIGNATURE OF TABLE

33. SIGNATURE OF CUPBOARD

34. SIGNATURE OF WARDROBE

35. SIGNATURE OF CLOSET

36. SIGNATURE OF BATH

37. SIGNATURE OF KITCHEN

38. SIGNATURE OF HALL

39. SIGNATURE OF PORCH

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260. SIGNATURE OF PORCH

261. SIGNATURE OF GARDEN

262. SIGNATURE OF YARD



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-35 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1842 CERTIFICATE OF DEATH

01847

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harre de GRACE</u>				TOWN <u>Port DePOSIT</u>		97X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp</u>				STREET ADDRESS (If rural give location) <u>md.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Arrie Mathena</u> (Middle) <u>Wolford</u> (Last)				(Month) <u>Feb.</u> (Day) <u>4</u> (Year) <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>3-20-1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Daniel Umbarger</u>				14. MOTHER'S MAIDEN NAME <u>Fannie F. King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>2-4-56</u>			
17. INFORMANT & ADDRESS <u>L. F. Wolford, Port Deposit, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Beckman's accident</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Tumor of adrenal (pheochromocytoma)</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on.....Feb.....4, 1956, and that death occurred at 12:00 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Wm K Brendler</u>				ADDRESS (Street, city, town, state) <u>Harre de Grace</u>		DATE SIGNED <u>2-4-56</u>	
M.D. <u>Harre de Grace</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-7-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Round Hill</u>		LOCATION (City, town, or county) <u>Marion, Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm K Brendler</u>		ADDRESS <u>Port Deposit, Md</u>	
DATE <u>Feb. 6 - 1956</u>							

